Abortion: an open letter

By Bette Stephenson, MD

I would like to stress that the statements I have made regarding the difficult subject of abortion and family planning are, in fact, the policy of the Canadian Medical Association established in the 1960s and early 1970s by majority vote of the representatives of all the medical profession at meetings of the Canadian Medical Association General Council. Those policies have not been altered since that time. Indeed, the experience of the intervening years has served to reinforce the validity of those policies in attempting to meet the needs of the society that we are pledged to serve.

Unfortunately, many people have, without knowing all the facts, developed firm opinions about the controversy involving the minister of justice and the CMA regarding this subject. It is impossible for me to outline all the important details, even in this lengthy letter, but allow me to outline a few of the very pertinent points involved.

- The CMA is not in favour of "abortion on demand"; indeed we are very concerned with the very large and growing number of abortions being performed. The association is most disturbed that, according to conclusive evidence in our possession, even more abortions are being performed on Canadian women than are indicated in the alarming figures released by Statistics Canada.

- Our primary aim is to improve family planning programs and, in every way possible, reduce unwanted pregnancies and the need for abortion.

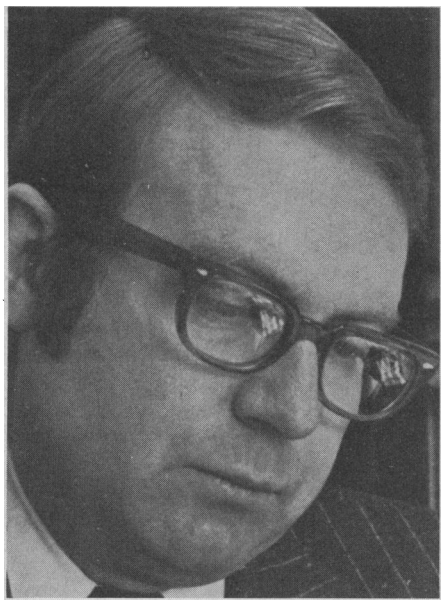
- We do not suggest that the law should be amended as a direct reflection of, or automatic reaction to, recommendations of the Canadian Medical Association. However, we do believe that government has a responsibility to conduct the long-promised review of the law and to recognize the obvious inadequacies of the current legislation and the gross inequity of availability of current programs and services for both therapeutic abortion and family planning.

- We believe there is a great need to clarify government policy regarding the abortion laws and for much more meaningful leadership from the federal and provincial governments and the medical profession of Canada to evolve an effective, comprehensive national family planning program.

With respect to our differences with the minister of justice, we have conducted a full, frank dialogue with him and other members of the government on this subject for several months. At no time has this association denied Mr. Lang's right to his personal views on the subject, his right to speak as the representative of those who elected him, his right — indeed his responsibility — to fulfil his duties as "the de-facto attorney general for the Northwest Territories" or, as so delegated, to serve as the spokesman for federal government policy on legal matters including those related to abortion. This association has not made, will not make and categorically rejects any responsibility for statements which relate Mr. Lang's personal religious affiliations to his actions as minister of justice. However, we have conclusive evidence of conflicting statements of government policy, and despite repeated efforts we have obtained no confirmation that either the minister's statements or his actions accurately reflect government policy. One is therefore forced to ask: is Mr. Lang serving as an official government spokesman on this subject?

According to *Hansard*, page 8124, April 29, 1969, the then minister of justice, John Turner, replied to a frequently asked question: "Health is incapable of definition and this will be left to the good professional judgement of medical practitioners to decide."

On Aug. 6, 1970 in answer to a specific enquiry, M. W. Hunter, execu-



". . health a broad word . . "

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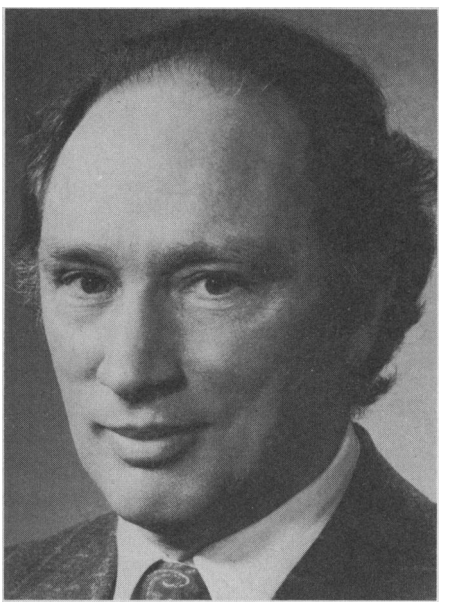


" . . leaves sufficient latitude . . "

tive assistant to the then minister of justice, John Turner (who steered the current legislation on abortion through Parliament) stated:

Mr. Turner has seen your letter of July 30, 1970 concerning Canada's abortion law, and has asked me to reply.

You are probably aware that the recent amendment to the Criminal Code permits a therapeutic abortion where the life or health of the mother is in danger.

Many groups and persons have been pressing for a further amendment to the law, but Mr. Turner is on record that he does not wish to contemplate further change until the medical profession and the hospital abortion committees have an adequate opportunity to explore the full latitude of the present definition. Mr. Turner is of the opinion that the word "health" is very broad and may include physical, psychological or social health. He frequently refers to the definition given by the World Health Organization which is as follows:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

In an October 1974 ministerial memo, Mr. Lang stated, "I advised the appropriate authorities, including therapeutic abortion committees, that the Criminal Code provisions regarding abortion were to be applied strictly: *that social and economic considerations were not to be taken into account* in determining whether a pregnancy lawfully could be terminated."

On Jan. 13, 1975 Mr. Lang stated, "I have made it clear that health is a broad word and a medical term that can certainly include mental and other factors." On that same day, in a statement to a Canadian Press reporter, Stewart MacLeod, the minister stated it was not true that he said economic or social factors could not be considered when deciding on abortions.

On Nov. 12, 1974 at the direction and with the approval of the CMA executive committee, I protested the actions and statements of the minister of justice to the Prime Minister as follows:

Rt. Hon. P. E. Trudeau
Prime Minister of Canada

Dear Sir:

On behalf of the medical profession of Canada, and in particular on behalf of our colleagues who voluntarily serve on hospital therapeutic abortion committees, I request your intervention as Prime Minister of Canada to realize a clarification of, and appropriate revisions to, section 251 of the Criminal Code.

As we have indicated in previous correspondence, it is rapidly becoming impossible for the medical profession to meet the responsibilities delegated to it in this legislation. This legislation, permitting and controlling therapeutic abortion, has proved to be discriminatory and in many parts of the country unmanageable.

Again, Sir, we acknowledge our share of the responsibility for the inadequacy of this legislation and the problems related to this subject. It is a fact that section 251 of the Criminal Code is extremely close to, if not based on, recommendations made to government by this association in 1966 and 1967. We regret that the government of the day did not authorize legal termination of a pregnancy where "the child may be born with a grave mental or physical disability . . . or where there are reasonable grounds to believe that a sexual offence has been committed from which pregnancy has resulted": yet the medical profession was pleased with the amendments made in the Criminal Code and believed them workable. Major changes in public and professional attitudes and experience have proved that our confidence in the workability of the legislation was misplaced. We believe there is need for major revision in the Criminal Code as suggested to you in our correspondence of Sept. 7.

In particular, this association wishes to point out that it does not concur with the interpretation of section 251 or "the intent or nature of the law" that is being propounded by the minister of justice. We question not only his interpretation but the propriety of his interpreting "the way Parliament intended the law to be applied". It has been our understanding that such interpretation is the prerogative and responsibility of the courts. For the minister of justice to advise or direct the enforcement of the law, by law enforcement agencies in the Northwest Territories, is a quite proper function in his capacity as attorney general for that area. However, for him to warn hospital authorities about the need to adhere to the dictates of the law as he interprets it constitutes an implied threat, can be interpreted as intimidation and in our opinion is a most improper course of action for the minister of justice.

We wish to emphasize that the Criminal Code does not provide a definition of health. Further, the Department of National Health and Welfare does not have, or operate under, any formal definition of health. Thus the abortion committees of Canada's hospitals are compelled to provide their own definition in order to fulfil the responsibilities delegated to them in section 251 of the Criminal Code. We would draw your attention to the most widely quoted definition of health—that of the World Health Organization in which Canada is a full participating member:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Following a full year of study, this association concluded it was incapable of producing an improvement on this definition. The recently released and much-praised working document of the Government of Canada, "A New Perspective on the Health of Canadians", places heavy emphasis on the necessity to consider social factors, personal behaviour or lifestyle etc. in our efforts to ensure "that

more Canadians live a full, happy, long and illness-free life."

We believe it is a responsibility of your government to provide a formal, functional definition of health, to clarify "the way Parliament intended the law to be applied" regarding abortion, via the courts or perhaps by allowing the current Parliament to provide that interpretation and to make the indicated legislative changes via the frequently promised parliamentary debate.

The physicians who serve on hospital therapeutic abortion committees, on a volunteer basis, have been delegated a most difficult, disagreeable responsibility. While it is obvious that there has been considerable variation in the manner in which they have met this responsibility, it is our contention that they have done so to the best of their ability. Recognizing the inadequacies of the law and the circumstances under which the committees have operated, we believe they have earned commendation, not condemnation. We believe that the statements and action of the minister of justice have been counterproductive, patently unfair to the committee members, and have made a very difficult task almost impossible. For example, most members of the profession find serving on abortion committees an onerous, unproductive, unrewarding — indeed a disagreeable — responsibility. They accept such positions on a voluntary basis — there are no monetary or professional benefits to be derived — because of an innate recognition that this professional responsibility must be met. They approach their responsibilities on therapeutic abortion committees with the attitude, "it's a miserable job but somebody has to do it, so I'll do the best I can for a while and get out as soon as possible." I repeat, to ask these physicians to continue to serve in this capacity under the condemnation and implied threats of the minister of justice is unfair. To recruit voluntary replacements is difficult under the best of circumstances. Under the current disadvantageous circumstances that prevail, aggravated by the statements and actions of the minister of justice, it is almost impossible.

In several parts of the country the problems related to this legislation and its management are critical. We urge you to take immediate action to seek solutions and if the Canadian Medical Association can be of assistance towards that end we would be pleased to be of service.

Response

On Dec. 16, 1974 the following response was received from the Prime Minister:

Dear Dr. Stephenson:

Thank you for your letter of Nov. 12 in which you so ably outlined the position of the Canadian Medical Association with respect to section 251 of the Criminal Code.

As you yourself state, most of the provisions of the law were significantly influenced by the recommendations of the Canadian Medical Association in 1966 and 1967. It was the earnest belief of the government at the time the law was enacted that these modifications to the Criminal Code would prove to be both just and workable. However, section 251 is still relatively recent in its origin, and consequently the government is continuing to monitor the effect of this section very carefully.

I would certainly grant that decisions made by individual hospital abortion committees are difficult and delicate in the extreme, but I do not see any way such decisions can be avoided, even given some iron-clad definition in the law of the concept of "health". No matter what the wording of any such definition might be, the decisions of hospital abortion committees would still concern very difficult human situations. In fact, one of the benefits of not having rigid definitions of conditions under which abortions may or may not be performed is that it leaves sufficient latitude for hospital abortion committees to make just decisions in the many borderline or unique cases which inevitably will arise in the course of a committee's deliberations.

While you may be assured that I fully understand the difficulties under which hospital abortion committees operate, I also want to assure you that in its public pronouncements this government has not meant to imply criticism of those who are assuming this very important, serious and complex set of professional responsibilities. Neither has this government meant to threaten members of the Canadian Medical Association. Indeed, we are grateful for the time and efforts which members of the association have spent working on hospital abortion committees.

Furthermore, I have taken the liberty of forwarding your letter to the minister of justice and the minister of national health and welfare for study and consideration of your comments. At this time, however, I feel it would be premature to reopen the law to further amendment, pending further experience with the provisions of the current law. Nevertheless, your comments, and those of your association, are sure to play a vital role in assessing the performance of the present law, and as such they are very much appreciated.

Release?

In response to my request to make the contents of his correspondence known to the medical profession of Canada, the Prime Minister replied Jan. 17:

Dear Dr. Stephenson:

Thank you for your letter of Jan. 9 which continued our most useful exchange of views on section 251 of the Criminal Code.

Let me say at the outset that I certainly appreciate the confidence with which you have treated my correspondence of Dec. 16. Nevertheless, I am conscious of the considerable interest of the Canadian Medical Association's membership in our exchange of letters and, as such, I have no objection to your disseminating our correspondence.

Because my office has been in receipt of occasional press calls on this matter, it would be advisable to release the texts of this correspondence to the media after you send it to CMA members.

May I thank you again for your consideration in consulting me about this matter.

May I present the context in which I am reported to have called for the resignation of the minister of justice? In response to a reporter's question, following my address to the Empire Club of Canada Jan. 9 (See *CMAJ* 112: 208, 1975), I replied, "If the minister of justice is stating government policy or position, that is a proper function. If the courts of the land provide us with an interpretation of ruling on the law, the matter will be clarified by those who have the responsibility to do so. But if Mr. Lang is simply voicing his own personal, in my view biased, opinions, I think the Prime Minister should seriously consider calling for his resignation or otherwise removing him from this portfolio."

Contrary to a frequent misinterpretation that the CMA is pro-abortion, the association, in fact, is much more strongly pro-prevention of the problem of unwanted pregnancy. If the news media had publicized that important portion of my presentation to the Empire Club — regarding the need for effective educational and family planning programs — as widely as it did that part related to the problems of abortion, you would have gained a much more accurate view of the policies of the association.

Although I was denied the opportunity to address the recent health ministers' conference, I am happy to report that our actions led to a most meaningful discussion on abortion and family planning at that meeting. The Canadian Medical Association is extremely pleased that the ministers of health at both the federal and provincial levels have agreed that they have a responsibility to ensure that adequate family planning information and services are available, including counselling services. In response to a request received from Marc Lalonde since that conference, the Canadian Medical Association will do all in its power to cooperate with the federal government to achieve the common objective of bringing factual information on family planning and family planning services to all Canadians regardless of place of domicile or socioeconomic status.

Yours sincerely,

BETTE STEPHENSON, MD,
CMA PRESIDENT

Saskatchewan MDs, government reach 1-year 'peace on the prairie' worth $6½ million

By D.A. Geekie

At a special meeting Feb. 2 in Regina, the Saskatchewan Medical Association accepted a straight payment settlement, a 15.75% increase in the government's 1972 schedule of benefits.

The increase which was based on 1973 utilization will apply for the 1975 calendar year and will be retroactive to Jan. 1. It will add about $7700 to the average Saskatchewan physician's gross payments and $6½ million to the province's medical care insurance bill. Fortunately for Saskatchewan taxpayers, approximately 60% of that will be borne by the federal government through cost-sharing programs.

Half across board

SMA President M. A. Gormley indicated at least 50% of the increase would be allocated on "an across the board basis to all segments of the profession although it will probably be realized by increasing the schedule of benefits on a cross section of items only." The balance of the increase, according to Dr. Gormley, would be used to further reduce income disparities within the profession.

This news triggered a move for the total increase to be reflected "across the board". However, Dr. Gormley ruled the motion out of order, and his ruling was upheld by the membership. He contended such adjustments to fee schedules were the prerogative and duty of the board based on recommendations of the association's economics committee.

Agreeable

Both government and more than 200 SMA members who met in the provincial capital found Stirling McDowell's new proposal agreeable. This was the mediator's second attempt to find something workable for both sides: his initial recommendation was rejected at a SMA special meeting last month. (See *CMAJ* special news report Jan. 25.)

At that meeting a secret ballot (270 to 31) rejected McDowell's proposal for a negotiated, written agreement, although it had been accepted by the SMA negotiating committee, recommended by the board and approved by a referendum vote of 305 to 215.

A larger majority of the members at that meeting opposed any move to modify mode 3 billing — the physicians' right to bill patients directly up to or beyond the SMA fee schedule

At last SMA annual meeting (from left) newly elected President M. A. Gormley and Vice president L. A. Lavoie along with Health Minister Walter Smishek reflect the calm...

"is not negotiable".

The rejected package sought to forbid SMA members to bill amounts higher than the SMA fee schedule rates, and any physician wishing to do so would be required to resign from SMA.

Planning impossible

Members also objected to the package's stipulation that they accept a 16½% increase over the 1972 fee schedule for 1975 (based on '73 utilization) and a further 5½% increase for 1976 (based on '74 utilization). Although they found the 1975 increase acceptable, most felt that present inflation on practice costs made planning beyond a year impossible.

The accepted recommendation has dispelled those objections: the agreement will run from Jan. 1 to Dec. 31, 1975 and the physician retains his right to deal with patients directly. While SMA announced it will continue to seek a written agreement drafted during negotiations, other principles negotiated in the early package — official recognition of the SMA as the negotiating agent for physicians, recognition of the SMA peer review committee, and the establishment of a formal grievance procedure to handle disputes (rights granted by government to practically every other segment of society) — have been lost, according to Dr. Gormley.

Saskatchewan physicians will also give up in excess of $350 000 during 1975; the benefit increase was reduced from 16.5% to 15.75% to retain their absolute freedom to deal directly with their patients. As one seasoned Saskatchewan clinician put it "We paid the price to maintain our professional freedom in 1962; we are paying for it again and will continue to do so. The right to deal directly with our patients, even if few of us actually choose to do so, is an absolute necessity to defend the professional integrity and independence of the profession. As we said in Trianon ballroom 12 years ago and in Saskatoon 2 weeks ago, that right is not negotiable at any price".

Interim 25% increase

During the 14-day grace period between the two special meetings, the SMA issued a new interim minimum schedule of fees to realize a 25% increase for each segment of the profession (a Jan. 19 directive). This will produce a much greater differential between the profession's schedule of minimum fees and the government's benefit schedule than has existed. While the percentage differential will vary according to the allocation decisions of the SMA economics committee, it will now frequently exceed 25%, whereas formerly it was 15%.

Several physicians announced they will opt out of the plan and bill patients directly — now more feasible and financially attractive. It is, therefore, expected that the number of physicians who currently practise in this manner will be sizably increased. ■

Ontario, Alberta medical associations gain compromise with provincial governments

By D.A. Geekie

At the regular midwinter meeting, held recently in Toronto, the governing council of the Ontario Medical Association agreed that, despite the effects of inflation on costs of practice and purchasing power, Ontario physicians will honour its 2-year gentlemen's agreement with the Government of Ontario.

In early 1974, the OMA and government, on the recommendation of their joint committee on physicians' compensation, agreed to a 2-year "contract" in which the government would continue to pay 90% of the OMA fee schedule and OMA would increase the schedule by 7.75%, May 1, 1974 and another 4%, May 1, 1975. The contract was to run to May 1, 1976.

The fall

By fall 1974 the OMA recognized the effects of inflation on this agreement and requested the joint committee which had been established as a result of a Pickering recommendation to consider revising the 4% increase for 1975 to allow for the rise in costs of practice. (Cost of living in Ontario increased 12% in 1974 and a further 11% jump is anticipated for 1975.)

Government officials on the committee concurred there was justification for such a review, but when the review was concluded, government decided not to consider increasing the 4% by even a nominal amount.

The actual OMA resolution passed by an overwhelming majority — fewer than 40 of the 275 members of council opposed it — followed a day-long debate:

That this OMA council representing a responsible and honourable profession reaffirms the position of the OMA council of February 1974 in that they will honour the agreement between the OMA and the government recognizing that this agreement does not take into consideration the marked inflationary trends of the economy with its serious economic effects on our members and associates.

Another resolution to come out of the meeting called for OMA to "continue its efforts to revise our schedule of fees as of May 1, 1976 consistent with the current rate of inflation independent of any further negotiations with government regarding the schedule of benefits." This resolution appeared to place the activities of the joint committee on physicians' compensation in some doubt. To date this committee has negotiated "an appropriate increase in the OMA schedule of fees" with government agreeing to continue its payment level of 90%.

Presumably the joint committee will continue its long-term study of alternative methods of paying for physicians' services and continue to negotiate the percentage of the OMA fee schedule payable by the provincial health insurance plan along with matters other than changes in the OMA minimum schedule of fees.

At a press conference OMA President M. Mador emphatically stated the fee schedule was the property of the profession and in future would not be subject to discussion with, or approval by, the provincial government. There is of course the possibility that the Ontario government will alter its practice of paying for physicians' services by producing its own benefit schedule.

It is ironical that, during the interval of about 2 weeks, Canada's medical profession in its largest most affluent province, Ontario, and one of its smaller, less affluent, less well supplied with medical manpower provinces, Saskatchewan, should come to the same basic conclusion: we will establish and print our minimum schedule of fees and government can decide what portion of that schedule it wishes to pay or alternatively publish its own schedule of benefits.

Alberta

In contrast to Ontario and Saskatchewan, the profession and government in Canada's oil sheikdom, Alberta, were able to come to a financial settlement with relative ease.

By a membership referendum that voted 96.5% in favour, the profession accepted a supplementary 7.2% fee schedule increase as of Mar. 1, 1975. The Alberta Medical Association and the government had been operating on an agreement reached in 1973 that provided a 4% increase on Oct. 1, 1973 and another 4% increase Oct. 1, 1974. This agreement was to remain in force to Dec. 31, 1975.

The Alberta government pays 100% of the AMA schedule as a medicare benefit: the only province in Canada to do so.

The 7.2% increase is to be based on utilization during the period from July 1, 1973 through June 30, 1974. An additional $1 million will be added to that to provide a cost base comparable to the 1974 calendar year utilization. The anticipated total cost of this increase to the province is $7.8 million.

Thanks to a recently conducted cost-of-practice study, the AMA is in a position to distribute the $7.8 million in a rather unique manner. Fifty percent will be allocated to various sections on a real dollar basis to partially compensate all practitioners for the inflationary rise in the costs of practice. The remaining $3.9 million will be portioned out to reduce income disparities between various segments of the profession. General practitioners will receive 60% ($2 340 000); the balance will be allocated to internists, pediatricians, neurologists, anesthetists, physiatrists and psychiatrists.

Announcement

AMA president Dr. R.E. Hatfield announcing the results of the referendum stated "both the government and the profession recognize the existence of an agreement that is binding on both sides. While we appreciate this tangible recognition of the increased costs of medical practice by government we know that the profession has lost considerable ground in terms of real disposable income since October 1973. The association will do everything possible to make up that lost ground when the current agreement expires on Dec. 1, 1975."

Dr. Hatfield also indicated that the association expects some concern will be expressed by some specialty groups regarding the manner in which the $7.8 million will be distributed. "This distribution has been authorized by the Board of Directors on the recommendation of both the committee on fees and income. The 4% increase of Oct. 1, 1974 was distributed across the board but there will still be complaints. All segments of the profession are feeling the effects of inflation. We have tried to recognize that fact via the $3.9 million real-dollar base increase to all sections but the AMA is dedicated to the correction of inequitable income disparities. As best we can, we have tried to evolve a fair compromise to partially meet those two objectives — to adjust all physicians' payments in keeping with actual increased costs of practice and to correct disparities."■

CMA issues brief on cannabis to Senate committee; calls for process to 'decriminalize' offence

The following sets forth the association policy on Bill S19 (cannabis control). This brief was presented to the Senate committee on legal and constitutional affairs Feb. 11, 1975. Association members of the CMA delegation were Drs. Bette Stephenson, L.P. Solursh and L.P. Chesmey. Staff members were D.A. Geekie, Dr. J.S. Bennett and Dr. M.P. DaFylva.

The Canadian Medical Association welcomes this opportunity to present the following opinions and information related to Bill S19, on behalf of its 26 000 physician members.

More than 7 years ago, Dec. 6, 1967, members of the medical profession, including a member of this delegation, first recommended to the Senate's standing committee on banking and commerce that "cannabis compounds, natural and synthetic, including marijuana, hashish and THC" be transferred from the Narcotic Control to the Food and Drugs Act. Your colleagues were considering Bill S21, an act to amend the Food and Drugs Act. In November 1969 the association formally submitted a comparable recommendation to the Government of Canada via its interim brief to the Commission of Inquiry into the Non-Medical Use of Drugs. The association is pleased, therefore, to see the Parliament of Canada, both here and in the lower House, is considering such legislation. It is highly desirable that the legal machinery of this country be granted more discretionary power and that the courts deal with the users of marijuana in a more lenient manner. As we have stated on several occasions: cannabis is not a narcotic and would be more appropriately controlled under the Food and Drugs Act; the simple possession of a psychoactive drug for personal use should not be punishable by jail sentence. We stress: in our collective medical opinion, definite health hazards accompany the use of cannabis and the public of Canada should be clearly advised against its use.

However, the association must view with considerable concern the failure of the legislation to eliminate the stigma — the possibility for criminal record. The social and health problems resulting from a criminal record far outweigh the crime of simple possession of cannabis for personal use. We reiterate our opinion forcefully expressed in the reports of Canada's Le Dain commission, the UK Wootton committee, and the US National Commission on Marijuana and Drug Abuse, 1972 that criminalization frequently produces far more serious, deleterious effects on the user than does the use of cannabis.

The CMA strongly urges that the legislation be amended to avoid the establishment of a criminal record for those found guilty of simple possession of cannabis for personal use. Failing the realization of that objective and notwithstanding the current provisions of the Criminal Law Amendments Act and the Criminal Records Act, we recommend that provisions be made for the automatic erasure of the criminal record for those found guilty (of simple possession for personal use) following a 2- or 3-year "charge-free probationary period".

Background information

Cannabis sativa L. is a herbaceous plant, which grows wild or can be cultivated in many areas of the world. It is from this plant that marijuana and hashish are obtained. Marijuana is usually a mixture of crushed cannabis leaves, flowers and twigs while hashish is the concentrated resin of the plant. The primary psychoactive constituents are certain forms of tetrahydrocannabinol (THC).

Cannabis is not grown purely for its pharmacological properties. Its fibres are used in industries — manufacture of rope, twine, cloth, paper, money — while its seeds produce oil used in paint and soap as well as being used as food for man, animals and birds. The plant has a recorded history of nearly 6000 years and appears to have been introduced, for commercial purposes, into North America in the early 17th century. Such cultivation in Canada continued until the 1930s, but in 1938 an amendment to the Opium and Narcotic Drug Act banned the cultivation of cannabis without special authorization.

As part of the current "drug scene", cannabis has achieved a fair degree of prominence and with it a tremendous amount of controversy. Since the early 1960s, a plethora of reports and opinions, both scientific and non-scientific, accompanied by emotional outpourings in many instances, has produced little towards solving the controversy.

In 1969, under an Order-in-Council, the Government of Canada set up a Commission of Inquiry into the Non-Medical Use of Drugs, and in 1970 this commission presented an interim report in which cannabis was discussed. In 1972 the commission produced a report devoted entirely to cannabis; this report had been preceded 2 months by a report from the US National Commission on Marijuana and Drug Abuse and in 1968 by the report of the Wootton committee in the United Kingdom.

Identification of the problem

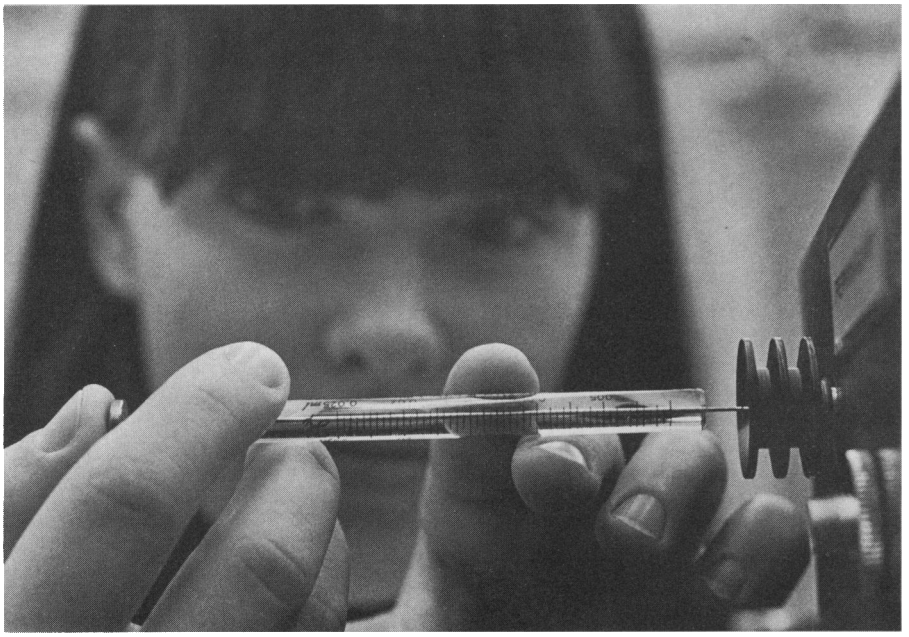
As stated earlier, there is an overlying aura of emotion whenever the drug problem is discussed. Most people would agree that not all use of alcohol indicates a problem and that an alcohol problem arises because of excessive use. However, those same people would argue that any use of cannabis constitutes a drug problem.

The cannabis problem cannot be viewed in isolation from other drug use. No drug is harmless. The utilization of any drug has to be looked at in terms of dose, potency, frequency of use, physiological response of the recipient. What may be inadequate for one person may be adequate for another. What may be harmless or beneficial to one patient may in similar amounts, etc. be harmful to another. This is the perspective in which the nonmedical use, abuse or misuse, of drugs must be viewed. To do otherwise inevitably leads to erroneous, invalid comparisons or conclusions or both.

Basically drug problems have two facets — the social and the medical sides. On the social side, possession, as opposed to use, may bring an individual into conflict with the law, even though the individual's action may not directly affect society. Overuse and misuse (including dependence) of a drug may bring the user into conflict with the law because of the direct, and sometimes the indirect, effect on society. The medical problems arise when abuse or misuse directly affects the health of the user.

The solutions to the two facets are not the same. The medical side has to be resolved by careful, well recognized scientific study, with proved scientific answers to the questions raised. The social problem does not depend on scientific conclusions alone for a solution but has to be resolved by an interaction involving value judgements, viable alternatives, education and the active involvement of government and private agencies.

Reprint requests to: D.A. Geekie, director, Department of communications, CMA House, 1867 Alta Vista Dr., Box 8650, Ottawa K1G 0G8.



Gas chromatography is used, in combination with a mass spectrometer, to detect presence of cannabis. Main drawback: cannot accurately determine amount.

The difficulties encountered in reaching acceptable conclusions may be seen in both the Canadian and US commission reports. In both there was a lack of unanimity on how to best handle the situation. Four of five members of the Le Dain commission recommended the repeal of the prohibition against simple possession of cannabis. Eleven of 13 members of the US commission recommended that "possession of marijuana for personal use no longer be considered an offense".

The Wootton committee recommended a substantial reduction in penalties for its use: "Possession of a small amount of cannabis should not normally be regarded as a serious crime to be punished by imprisonment." Under the Misuse of Drugs Act 1971 (which came into force July 1, 1973), cannabis and cannabis resin fall into category B; illegal possession of substances in this category on indictment may lead to a maximum penalty of 5 years imprisonment or a fine, or both. Quantities are not specified in the act. Cannabinol, except when contained in cannabis or its resin, falls into category A; indictment for its unlawful possession may lead to a maximum 7 years imprisonment or a fine, or both. However, there are provisions for dealing with offenders summarily, and the penalties are much less severe than for offences tried on indictment.

In November 1969 the CMA submitted its interim brief to the Le Dain commission stating: "The medical profession, like most segments of society, has been extremely conscious of the rapid increase in utilization of the various forms of *cannabis sativa*. This, the most extensively used drug among our youth and young adult drug users, has been as much a centre of intense controversy and contradictory reports within the profession as it has been for the general public." The CMA went on to urge that decisions not be based on "inadequate scientific evidence".

In its brief, the association asked that marijuana be regulated under the appropriate schedule of the Food and Drugs Act rather than under the Narcotic Control Act. The brief commented also on the "harmful effects of police apprehension, conviction and its resultant criminal record and incarceration with hardened criminals of the youthful marijuana user".

The association continued to discuss the question of nonmedical drug usage and in 1971 presented a further brief to the Le Dain commission. Among the 17 recommendations were the following:

- That simple possession of any psychoactive drug should not be punishable by jail sentence.
- That legislation be enacted to provide for the destruction of all records of a criminal conviction after a reasonable period of time.
- That the legal definitions of "trafficking" and "possession for the purpose of trafficking" be reviewed and clarified.
- That control of psychedelic drugs, cannabis products and similar substances and the legal machinery for dealing with users be health oriented — that is, under the Food and Drugs Act as opposed to the Narcotic Control Act, pending review of the current pertinent legislation.

In its reaction to the final report of the Le Dain commission, the association noted with approval that the commission had recognized the nonmedical aspects of the problems of nonmedical drug use. The association reiterated its policy on the need for "decriminalization of those convicted for simple possession of cannabis" and called upon the Department of Justice "to undertake the job of clarifying the definitions of simple possession, drug trafficking and reviewing the whole range of penalties for drug trafficking".

The CMA's interpretation of "decriminalization" and "use" is as presented to the 1974 annual meeting of the association in keeping with the recommendations of a CMA-Canadian Bar Association joint committee, *viz*:

> Decriminalization is the concept referred to in both the US and Canadian drug commission reports, *i.e.* 'criminal' means an act included in the Criminal Code of Canada, whether the offence be prosecutable or prosecuted by the summary route or by indictment, and as such 'decriminalization' is the removal of such offence from the code.

With respect to the "use of drugs" we believe it should be defined as the presence of a drug within the body, rather than defined in terms of anecdotal reports of an individual who has taken a drug; "use of drugs" *per se* should not be a criminal offence. In those cases where use is associated with, or leads to, activities which contravene existing civil or criminal law, the appropriate existing laws should apply.

During the past 3 years the association has firmly opposed any move towards legalization of cannabis and its products, indicated the need for further scientific research on cannabis, recommended that the general public be made aware of the potential hazards involved in the use of cannabis, and consistently supported the concept of decriminalization for simple possession offences.

Current medical thinking

There is an increasing body of evidence that marijuana may not be the relatively harmless substance it was thought to be, and scientific observations over the past 5 years have suggested that there are definite hazards in its use. The evidence indicates the effects of marijuana are dose-related and cumulative; at least six different potential hazards have been pin-pointed. These are irreversible brain damage, personality changes, damage to respiratory system, interference with hormonal production, disruption of cellular metabolism, and chromosomal damage.

These potential hazards have been determined mainly from the clinical experience of physicians. Therefore, these observations are less reliable than re-

sults obtained in controlled clinical trials where the subject's drug use can be monitored. Because of this, the controversy which surrounds the degree of hazard resulting from casual cannabis use will not soon be resolved.

While some clinical trials have been held to determine effects of cannabis, the results have not produced clear answers. Some of the findings have not been replicated in similar trials.

Examination at the University of Utah school of medicine and at New York University school of medicine demonstrated chromosomal abnormalities in the long-term user, but not in the casual user. However, contradictory evidence comes from the New Jersey Institute for Medical Research where subjects given cannabis under controlled conditions showed no chromosome abnormalities.

There appears to be agreement among some researchers that extended exposure to cannabis interferes with the synthesis of desoxyribonucleic acid (DNA). The long-term use lowers the immune responsiveness and thus would make the user more susceptible to disease. It is believed that it is the non-psychoactive components, cannabinol and cannabidiol, which are more effective than THC in the depression of DNA synthesis.

Work at the University of Toronto has shown that THC has a marked depressive effect on the synthesis of ribonucleic acid and work at the Mason Research Institute, Worcester, Massachusetts has shown that THC given in high doses to experimental animals, produces changes in brain tissue.

Studies at the Reproductive Biology Research Foundation, St. Louis, Missouri showed that 20 young men who had used cannabis at least four times a week for 6 months or longer had lower than normal blood testosterone levels. Another effect attributed to cannabis use is gynecomastia — production of female-like breasts in males.

Marijuana cigarettes contain about 50% more tar than commercial cigarettes, and this marijuana tar has produced skin tumours on mice. Bronchial biopsies on young US soldiers who smoked hashish showed a high percentage of premalignant or early-malignant lesions. Work at the University of Oxford shows an increasing incidence of emphysema among young smokers of cannabis, a finding consistent with findings in ganja smokers.

However, it must be stated that the bulk of cannabis smokers also smoke tobacco and the latter may predispose the bronchial tissue to pathological changes. Tobacco is usually selectively bred for its mildness, and there are attempts to keep the tar content to low levels. No such attempts have been made with cannabis, and sometimes tar content has been found to be 50% higher than tobacco tar content; therefore, cannabis by itself may contribute significantly to lung irritation.

To produce its psychedelic effect, cannabis must have at least some specific action on the central nervous system. THC has a very high affinity for brain tissue, and with repeated doses, there is a build up; traces may be found for varying periods after the administration is discontinued.

It is believed that the continued presence of THC in brain tissue leads to a syndrome which has been described as amotivational. Subjects show apathy, sluggishness, flattening of affect, lack of goals and loss of interest in personal appearance.

However, there is still disagreement over the link between heavy, prolonged use of cannabis and brain damage, and much more research will be needed before answers are forthcoming.

In summary

In looking at the proposals outlined in Bill S19, the CMA is pleased to see that cannabis will be placed under the Food and Drugs Act, that the legal machinery is given greater discretion and that the courts have direction to deal with minor offenders in a more lenient manner.

However, the association must strongly disagree with the retention of the criminalization which may result from simple possession and reiterates its opinion, expressed in the reports from Canada, the UK and the USA, that the criminalization frequently produces far more serious, deleterious effects on the user than the original use of cannabis.

The CMA is concerned not only about the social implications of the criminal appelation. It is obvious that such a label may have a direct bearing on the total health of the individual, and the association asks that simple possession, not for the purposes of trafficking, be considered a non-criminal offence.

The association does not recommend "legalization". It has asked for review and clarification of "trafficking" and "possession for the purpose of trafficking". These are matters for consideration by those with legal expertise. Even allowing for the provisions of the Criminal Law Amendments Act and the Criminal Records Act, the association believes most strongly that removal of the appropriate section of the Criminal Code is a most appropriate and logical step at this time. We urge the Parliament of Canada to study the experience of New Zealand and the state of Oregon, USA relative to this subject. ■